DATE: October 26, 1995 BQC 95-047

TO: Nursing Homes NH 33
Hospitals HOSP 19

FROM: Judy Fryback, Director
Bureau of Quality Compliance

SUBJECT: Questions and Answers on Use of Restraints in Wisconsin Nursing Homes

In December 1993, the Bureau of Quality Compliance (BQC) conducted five programs on restraint reduction. At that time, Wisconsin had 31.5 percent of the residents in nursing homes restrained. The national average was 22.0 percent, with only two other states having a higher percentage of nursing home residents restrained. These numbers have not improved since BQC presented the restraint reduction program. At the present time, 33.4 percent of residents in Wisconsin nursing homes are restrained, compared to a national average of 21.6 percent.

The enclosed document provides responses to the questions raised at the 1993 restraint reduction programs, as well as responses to subsequent questions that the Bureau has received about this topic.

Because many residents of nursing homes are admitted from hospitals or have episodes of illness that require hospitalization, we are sharing this information with hospitals as well. A number of the questions relate to issues of residents moving between hospitals and nursing homes. It is hoped that discussions between hospitals and nursing homes will improve care coordination on restraint issues.

If you have questions on the content of this document, please contact the Bureau of Quality Compliance Regional Field Offices that are responsible for nursing homes, or the Hospital and Health Services Section that is responsible for hospitals. The phone numbers for these offices are listed below.

Madison/Southern Regional Office
3514 Memorial Drive, Madison WI 53704
(608) 243-2370

Green Bay/Northeastern Regional Office
200 N. Jefferson St., Green Bay WI 54301
(414) 448-5240

Milwaukee/Southeastern Regional Office
819 N. 6th Street, Milwaukee WI 53203
(414) 227-5000

Eau Claire/Western Regional Office
312 S. Barstow St., Eau Claire WI 54701
(715) 836-4752

Hospital and Health Services Section
111 W. Wilson St., Madison WI 53701
(608) 266-8084

Attachments

cc:-BQC Staff
-Office of Legal Counsel
-John Chapin, Interim DOH Admin.
-Kevin Piper, BHCF Dir.
-HCFA, Region V, Mark Dykstra
-Illinois State Agency
-Ohio State Agency
-Michigan State Agency
-Indiana State Agency
-Minnesota State Agency
-WI Coalition for Advocacy
-Serv. Employees Inter. Union
-WI Counties Assn.
-WI Health Info. Mgmt. Assn.
-WI Assn. of Homes & Serv/Aging
-St. Med. Society (Comm. Aging...)
-WI Health Care Association
-WI Assn. of Medical Directors
-Admin., Division of Care and Treatment Facilities
-WI Assn. of Hospital SW and Discharge Planners
-Bd. on Aging & Long Term Care
-Bur. of Design Prof., DRL
-WI Hospital Assn.
-LTC BQC Memo Subscribers
-Non-LTC BQC Memo Subscribers
-Mark Bunge, BPH
-DD Board

PART 1: DEFINITIONS

1. **What is the regulatory and operational definition of a restraint?**

HCFA Manual Transmittal 274, which includes the Interpretive Guidelines for 42 CFR 483.13(a), is the source for the following definitions:

Physical Restraint:

"Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body."

Chemical Restraint:

"A psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms."

2. **In order to be considered a restraint, does a device or intervention need to meet both parts of the restraint definition: (1) "cannot remove easily" (2) "restricts freedom of movement or normal access to one's body"?**

Yes.

3. **When is a side/bed rail considered a restraint?**

A side/bed rail is considered a restraint when the rail restricts the resident's freedom of movement or normal access to her/his body and the rail cannot be easily removed by the resident.

The use of bed rails (whether partial or full) as restraints is prohibited unless the rails are necessary to treat a resident's medical symptoms.

4. **Does answer 3 apply to all lengths of side/bed rails?**

Yes. The focus of the decision of whether a side/bed rail is a restraint lies in the purpose, medical symptom and clinical assessment of how the rail impacts on the needs of the individual resident, not the size or length of the side/bed rail.

5. **Is the use of just one side/bed rail a restraint?**

Yes, if it cannot be easily removed by the resident it may be a restraint. The focus of the decision of whether a side/bed rail is a restraint lies in the purpose, medical symptom and clinical assessment of how the rail impacts on the needs of the individual resident, not the number of side/bed rails.

6. **When can side/bed rails be used?**

A rigorous clinical assessment of the resident's medical need for the side/bed rail must be completed and address that the side/bed rails are necessary to assist a resident in attaining or maintaining her/his highest practicable physical, mental and psychosocial well-being. The assessment must also show how the use of the side/bed rail would treat the cause of the medical symptom. This comprehensive assessment should include, but is not limited to:

a. A review of the resident's:
    1. Bed mobility:

- Would the use of the side/bed rail assist the resident to turn from side to side? or
- Is the resident totally immobile and cannot shift without assistance?

2. Ability to transfer between positions, to and from bed or chair, to stand and toilet:
   - Can the resident transfer safely with no risk of falling? Moderate risk? High risk?
   - Would using a side/bed rail add to or detract from that risk?

b. An evaluation of less restrictive alternatives that were investigated before resorting to side/bed rails. Only if, and when, these other less restrictive practices have been ruled out as ineffective, should side/bed rails be used.

For residents assessed as medically requiring side/bed rails, an individualized care plan is required that addresses the medical need and includes identified approaches to meet the medical need. In the individualized care plan, the facility must engage in a systematic and gradual process toward reducing the use of the restraint; for example, lessening the time the side/bed rail is used while increasing the use of less restrictive alternatives. Other interventions that the facility might incorporate in care planning may include:

- providing restorative care to enhance abilities to stand safely and to walk;
- a trapeze to increase bed mobility;
- placing the bed lower to the floor and surrounding the bed with a soft mat;
- equipping the resident or bed with a device that monitors attempts to rise from the bed;
- providing frequent staff monitoring at night with periodic assisted toileting for residents attempting to arise to use the bathroom; and/or
- furnishing visual and verbal reminders to use the call bell/light for residents who are able to comprehend this information.

The resident's right to participate in care planning and to refuse treatment, including the right of the resident to accept or refuse the use of side/bed rails, must not be denied. Also see question/answer #13.

7. **Are side/bed rails elevated at the resident's request considered a restraint? If so, should the physician's order reflect that this is a resident request?**

For the resident to make an informed choice about the use of side/bed rails, the facility should explain to the resident the negative outcomes of restraint use.

However, the resident's request is not the determining factor of whether the side/bed rail is a restraint. The physician order does not need to reflect the resident's request for side rails.

The clinical assessment of the individual, i.e., whether the side/bed rail restricts the resident's freedom of movement and if the resident is unable to easily release the rail independently, determines the definition of the side/bed rail usage. If the rail(s) meets the definition of a restraint, it is a restraint even if the resident requests it and a physician's order would be required. There is no requirement to have the resident's request included in the physician's order.

However, if the resident requests a side/bed rail and the clinical assessment indicates that the rail does not restrict the resident's freedom of movement and she/he can easily remove the side/bed rail, the rail is not a restraint and its usage would not require a physician's order.

8. **I recently read in a professional journal that is frequently read by nursing home staff that if the resident consented to the restraint, that it was not really a restraint. Is this true?**

No, this is not consistent with state and federal regulations. Even though the resident consents to the restraint, it remains a restraint if it meets the definition of a restraint. It is expected that every resident (or their guardian if they are incompetent, or their health care agent if they are incapacitated) who has a medical necessity for a restraint is consulted and agrees with the decision to use a restraint.

9. **Are side/bed rails used for residents who are comatose considered a restraint?**

It depends on the resident and the results of the comprehensive clinical assessment.

If the comatose resident is capable of unpredictable involuntary movement and the side/bed rails are used to restrict that movement, then the side/bed rails would meet the definition of a restraint since this individual would not be able to remove them.

Side rails, in combination with pillows, can help in positioning the comatose resident and may be a necessary and/or appropriate intervention. However, the rails might still be classified as a restraint depending on the assessment of the individual's medical need for the side rail.

10. **Do side/bed rails need to be released every 2 hours or do staff just need to check on them?**

Per s. HSS 132.60(6)(f), Wis. Adm. Code, a restrained resident needs to be checked frequently enough to meet their needs based upon their assessment, but at least every 2 hours, to see that the resident's personal needs are met and to change the resident's position. Based on the assessment and care planning process, the need to release a side/bed rail may vary depending on the individual needs and/or wishes of the resident.

11. **If an article or device is deemed a restraint, what procedures and documentation are required so that it can be used?**

In terms of procedures:

** Physician's order that include the reason for the restraint and the period during which the restraint is to be applied. *(s. HSS 132.60(6)(b), Wis. Adm. Code)*

** Informed consent of the resident, guardian or surrogate decision maker to utilize or refuse some form of restraint.

** Designated periods in the day and a method that allows the resident to be free of restraints.

** Restraints checked at least every 2 hours and provision of comfort needs, range of motion, repositioning and appropriate exercise and ambulation at that time.

** Routine check on resident when restraint is in place.

** Review of restraint use on a continuous and ongoing basis to determine if the restraint is still necessary, if a less restrictive intervention is possible, and if restraint-free periods should be adjusted.

Documentation required of:

** The medical, psychosocial and physical assessment addressing the medical need for the intervention, symptoms that are being treated by the restraint, including consideration of the restraint Resident Assessment Protocol (RAP).

** Alternate, least-restrictive therapeutic interventions that were attempted and were unsuccessful.

** The disciplines consulted in the assessment.

** The resident's, guardian's or surrogate decision maker's participation in the decision making in developing the care plan for restraint usage.

Documentation could include:

** Basic nursing documentation required by state and federal regulations.

** A documentation flow sheet; each facility should determine the method it will use to meet its documentation needs.

** A schedule or plan of rehabilitative training to enable a systematic and gradual removal of restraints or progressive use of less restrictive interventions in the plan of care.

12. **Please define and differentiate between a restraint and an enabler / positioning device / lateral support.**

A device could be both a restraint and an enabler, positioning device or a support, depending on how it's used.

If a pillow, for instance, helps to keep a person upright while in a chair and meets the definition of a restraint because it restricts the person's freedom of movement and can not be easily removed at will, it is both a restraint and an enabler. Often an enabler that meets the definition of a restraint turns out to be the least restrictive intervention.

An article or device that meets the definition of a restraint can be quite appropriate depending on the resident's situation and what is learned from the comprehensive assessment.

13. **Does resident request change the definition of a restraint?**

No. The resident's desires do not determine if a particular item meets the definition of a restraint. How a device is defined as a restraint is solely dependent on how the article or device is used. If the article or device restricts freedom of movement and the resident can not easily release or remove it, it is a restraint. This applies to all devices/articles, including side rails.

For the resident to make an informed choice about the use of a restraint, the facility should explain to the resident the negative outcomes of restraint use.

14. **Are reclining geri-chairs, Merry Walkers, and lap trays considered a restraint? If so, under what circumstances?**

They are considered restraints if the item restricts the resident's freedom of movement, i.e., if the chair prevents the resident from rising, and the resident can not easily remove the article(s).

Use the comprehensive assessment to determine if a geri-chair, Merry Walker or lap tray is the least restrictive intervention for the medical needs of the individual and if its usage meets the definition of a restraint for the person. The facility would not be expected to utilize these devices as a restraint except to treat medical symptoms, which had been identified through a comprehensive assessment, with a care plan established to provide time-framed objectives for utilizing the device to treat those medical symptoms. If the assessment and care plan process determined that the device, i.e., the Walker, would be advantageous in assisting the resident to ambulate, then the resident would only be confined in the Walker for specific periods for which the device has been determined to be

a therapeutic intervention. Staff must be available to release the resident from the Walker when the period of ambulation is completed.

Assessing the cognitive ability, and level of confusion or alertness of the individual are both important parts of the assessment in that these factors impact upon an individual's ability to release the device. For a comatose resident who is capable of uncontrolled involuntary movement, and the geri-chair and/or lap tray is being utilized to restrict the involuntary movement, the geri-chair and/or lap tray would be a restraint in this instance.

15. **Is a wander guard bracelet a restraint?**

Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered restraints.

16. **Is hypnosis considered a restraint?**

No. Hypnosis is a treatment.

17. **Is a self-releasing seat belt considered less restrictive than a regular seat belt if the resident is unable to physically remove it?**

No. If the resident is unable to easily remove the "self releasing" seat belt due to physical or cognitive impairment, it is as restrictive to that person as a regular seat belt and is considered a restraint.

18. **How are waterbeds, mattresses on floor, etc., which are alternative approaches to vest, belt restraints, etc., viewed? These approaches offer freedom of movement and only prevent dangers of falls, etc.**

The determining factor of whether these approaches are restraints (although they may be less restrictive alternatives) is the comprehensive assessment of their use for the individual. In some cases, a waterbed or mattress on the floor may restrict freedom of movement for an individual and the individual may not be able to get out of the waterbed or off of the mattress.

19. **Must we try an alternative/reduction of restraint (side/bed rail or vest or other type) on each resident who has a restraint?**

Yes.

How often?

Restraint reduction is an ongoing cyclical process of assessment and care planning to determine, through alternative approaches, the least restrictive intervention, if any, for the individual. Because of this, the time frame will be different for each individual.

What if the family disagrees?

Family, if legally authorized to make health care decisions, must be able to make an informed decision. The facility must explain to the family the positive and negative outcomes of restraint use and provide education to the family regarding restraint reduction.

The legally authorized family member(s) cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms.

What if staff disagree?

Staff should be involved in the inter-disciplinary assessment process as well as the inter-disciplinary care planning to be fully informed of the reasons for the plan that was developed and, therefore, supportive of the resident's informed decision.

20. **What are current guidelines or regulations for emergency short-term use of restraints?**

HCFA Transmittal 274 guidance to surveyors states:

> "If the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has notice that the resident has previously made a valid refusal of the treatment in question."

Section HSS 132.60(6)(c), Wis. Adm. Code states:

> "A physical restraint may be applied temporarily without an order if necessary to protect the resident or another person from injury or to prevent physical harm to the resident or another person resulting from the destruction of property, provided that the physician is notified immediately and authorization for continued use is obtained from the physician within 12 hours."

21. **A resident uses a lap tray only in the dining room to enable her to be independent with feeding (or minimally assisted). It is put on when she comes in the dining room and is removed after she leaves. Is this a restraint?**

Yes, if the resident can't remove it. It may be an appropriate intervention for an intended secondary purpose, her meals, but it is a restraint during its use.

22. **What if I am using a wedge cushion for a resident who is <u>unable to stand</u>, but using it to prevent sliding, is it a restraint?**

This would be considered a restraint only if the wedge cushion cannot be easily removed by the resident AND it restricts freedom of movement that the resident has the ability to perform or restrict normal access to the resident's body.

23. **What if I am using a wedge cushion for a resident who <u>could</u> stand up and the wedge prevents standing, a restraint, correct?**

Yes, if the wedge cushion cannot be easily removed AND it restricts freedom of movement or normal access to the resident's body.

24. **Are hand splints a restraint?**

<u>Scenario 1:</u> Flaccid arm with wrist drop and edema with no active movement where splint enables proper positioning to reduce edema and prevent joint or nerve damage.

Answer: No

<u>Scenario 2:</u> Splint for tightly contracted hand where due to shortened tendons and/or muscles, there is no longer active movement, but splint enables proper positioning to prevent skin breakdown and promote patient comfort.

Answer: No

Scenario 3: Arm board with hand immobilized via gauze, tape or other material to restrict the hand grasp reflex for a resident who is pulling out feeding tubes/IV therapy, scratching self, etc.

Answer: Yes, and would require physician's order, assessment, reassessment and care planning.

25. **If a device is to be used as an enabler but it is also assessed as a restraint, do we still need a physician's order for a restraint? For an enabler?**

You do not need a physician's order for an enabler if the device is truly assessed for the resident as an enabler only and does not meet the definition of a restraint.

You do need a physician's order for a restraint if the device is assessed and defined for the resident as a restraint.

If the device is assessed and defined to be both an enabler and a restraint for the individual, a physician's order is required for the restraint usage.

26. **A resident scratches her/himself with fingernails. An attractive sock is put over the resident's hand. Hence the resident is able to still touch the same areas of her/his body but does not scratch self. Is this a restraint?**

Yes. This would restrict normal access to the resident's body. The assessment may show, however, that there is a justifiable medical reason to do this, such as an open sore/wound. In this case it would be a restraint but may not be in conflict with the intent of the regulations and a deficient practice may not exist.

27. **Please explain how a pillow is classified as a restraint.**

If the pillow restricts freedom of movement or access to the body that the resident would normally have, and cannot be easily removed, it is a restraint. The intent for its use would be documented in the assessment and the restraint Resident Assessment Protocol (RAP). This will determine if the intent is to restrict movement or access to the body, or a positioning device. The location of this information would be documented on the RAP summary sheet.

PART 2: SURVEY ISSUES

28. **Does the state support / promote the use of sensor pads, or mattresses on the floor, etc. as an alternative to side/bed rails?**

BQC encourages facilities to explore alternatives to physical and chemical restraints. Often it is possible to find a creative alternative to restraint use. If you are not sure if an alternative idea might require a waiver of a state regulation, please contact the Regional Field Operations Director to discuss case-specific requests.

29. **Will the Medical Assistance (MA) program pay to replace a bed so that we can get one that is lower to the floor?**

Yes. The MA program will reimburse the facility through the normal MA reimbursement process via cost reporting. Payment will occur in the following rate year.

30. **Scenario: The doctor, family and resident all agree on the use of a particular device to assure resident safety, all assessments have been performed and the surveyor cites the facility for inappropriate use of restraints.**

This should be a very rare situation but could happen if, for example, restraint use is not the problem but the restraint was applied incorrectly.

However, if you have a question with a cite and are not satisfied with the surveyor's explanation, you may contact his/her immediate supervisor who is the Regional Field Operations Director in the BQC Regional Office. You may also write for an interpretation of a rule to the BQC Regional Office; or the Long Term Care Section Chief, P.O. Box 309, Madison, WI 53701-0309.

31. **What regulation affords surveyors the ability to overrule a physician's order and the resident's consent to use of a restraint?**

Surveyors are comparing the practice of the facility to the requirements of federal and state laws, and writing deficiencies if the facility practice does not coincide with the regulation.

The surveyors are not overruling the physician nor the resident's consent, but may determine that the restraint is being used for discipline or convenience and not to treat medical symptoms, or that an adequate assessment of the medical need for the restraint has not been done. In addition, the surveyor may determine that the resident in consenting to the restraint had not been fully informed of all risks and benefits and offered viable alternate and less restrictive interventions. (Also see question #33 and response).

32. **The expectations and demands of each survey team are different. What should a facility do if a program approved for a resident one year is rejected as inappropriate during a subsequent survey?**

The guidelines used by the surveyors to determine if the regulations are being met are the same ones that have been sent out to all facilities in BQC memos and federal guidelines.
As indicated in this guidance to surveyors, resident assessment and care planning is a dynamic process. At any one point in time, resident care needs may require reassessment, care plans updated and less restrictive alternatives tried over time. A program of restraint for an individual that doesn't change over the course of a year could be a flag for the surveyors to determine if adequate assessment, reassessment and care planning has been done to meet the individual's needs and goals.

33. **How do we resolve differences in professional judgement of facility and survey staff. This is a subjective area. Why should a surveyor's judgement always overrule our staff judgement? We work on a daily basis with the resident, family and attending physician.**

While the industry and BQC share common goals, BQC surveyors have a different set of responsibilities in relation to those goals. Their job is to compare the practice of the facility to the statutory requirements in the Social Security Act and the regulations promulgated thereunder and in Ch. 50, Wis. Stats., and Ch. HSS 132, Wis. Adm. Code. Practice that differs from these requirements is documented as a statement of deficiency. Most cites related to restraints reflect lack of comprehensive assessment, or use of restraints that are not medically necessary. It is important that the resident's records reflect the rationale for the decisions made in relation to this issue.

34. **In the answer to question number 33 above**: **please define what is meant by "medically necessary."**

"Medically necessary" means a determination that is based on comprehensive and specialty assessments related to specific conditions that the reason for the restraint is medical and not environmental stimulation, hunger, pain, etc. The assessment also determines that the restraint will promote functioning, enhance quality of life, or prevent deterioration, and is the least restrictive measure. Examples of medical conditions could include a hip fracture or pulling out tubes.

35. **How do we reconcile resident rights and restraint reduction mandates?**

Since residents have the right to refuse treatment and participate in planning their care, they can refuse to give up a restraint. If so, the facility is responsible for insuring that the resident's choice is an informed choice. This

includes full information about all risks and benefits and is offered viable alternates and less restrictive interventions.

The goals of resident rights and restraint reduction are not contradictory. However, it may be necessary to establish a hierarchy, and if a resident does refuse to give up a restraint, this right must be recognized. (Also see questions #43, #44, #50 and responses.)

36. **Restraints that are routinely employed in the hospital setting become major cites if continued when the patient transfers to a nursing home. Over 65% of our patients are admitted from hospitals. What is BQC doing to seek restraint reduction in hospitals? Families and physicians can't understand why restraints employed for patient safety in the hospital must be removed when the patient enters a nursing home.**

BQC supports efforts to change standards for hospitals and is actively working with a number of organizations to develop new standards of care. Also, the Joint Commission on the Accreditation of Health Care Organizations is doing the same.

BQC does not advocate for "restraints employed for patient safety in the hospital being removed when the patient enters the nursing home." When the resident is admitted to the nursing home, the assessment process begins and the assessment for restraint reduction also begins. If, for a period of time, assessment by staff determines there is a medical need for a restraint for safety, and the resident agrees, then that should be reflected in the care plan. However, this is not a permanent decision, but one that needs to be reassessed periodically. A time frame should be set to try less restrictive interventions.

37. **How does BQC calculate an individual facility's percentage of restraint use?**

Data on restraint use is generally compiled from the HCFA federal database on survey and certification, called OSCAR (Online Survey Certification and Reporting). This system contains the results of all federal certification surveys conducted nationally over the past year. The resident demographic information including the percentage of residents who are restrained is self reported by the facility on the facility roster/matrix that the facility must complete at the start of the survey.

38. **Are side/bed rails included in calculating the facility's percentage restraint use?**

Yes. Those side/bed rails that clearly meet the definition of a restraint for each individual are included in preparing the counts on the roster/matrix form.

PART 3. ASSESSMENT AND DOCUMENTATION

39 **How often must a facility reevaluate the need for a restraint?**

The minimum period of time for reevaluation is quarterly, or as the resident's condition changes. The key is to individualize this decision, and to reevaluate when it is called for by the resident's situation, i.e., when the resident's response to care changes, or there is a noted change in a resident. The restraint use should be reevaluated regardless of whether "it is time" for the scheduled care plan review.

In looking at how often restraints need to be re-evaluated or reviewed, the staff also needs to consider more subtle changes. Examples:

X Does the resident move into very risky positions with the restraint, i.e., vest restraint under chin, belt restraint under rib cage? Deaths can easily occur when a resident moves involuntarily and can become wedged between the side/bed rail and the mattress.

X Some residents may be temporarily confused at admission and may be able to discard the restraint soon after admission. Other residents may have their mental status altered due to irritation and agitation caused by the restraint. This also needs to be considered. A monitored trial with less restrictive or no restraint usage may solve the problems.

40 **What are the guidelines for assessment and documentation?**

Guidelines include, but are not limited to, the federal regulations and interpretive guidelines, Wisconsin state administrative code, the comprehensive assessment including the Minimum Data Set, and Resident Assessment Protocols (RAPS), especially for psychotropic drug use and physical restraint use. Documentation of the assessment needs to follow the instructions in the resident assessment manual, the federal regulations including F514, complete and accurate medical records and current standards of practice for the maintenance of medical records.

Particular federal regulations, along with the guidance to surveyors that need to be particularly considered, include the following:

F150 - Resident Rights

F154 - Fully Informed of Health Status

F155 - Right to Refuse Treatment

F157 - Informed About Changes in Care and Treatment

F163 - Fully Informed in Advance about Care and Treatment
- Participate in Planning Care

F221, F222 - Right to be Free From Any Restraints Not Imposed to Treat Medical Symptoms. *Note - This area deals indepth with the need for restraint reduction and the use of the less restrictive restraints.*

F241 - Dignity

F272 - Comprehensive Assessment
- Minimum Data Set Including the Resident Assessment Protocols
- Special Treatments or Procedures

41 **May a qualified staff member conduct the review or must the entire team be involved?**

Qualified staff should review each resident=s needs and respond to treatment and care and note changes, on a continuous, ongoing basis. It can be done by one person if this person has the professional expertise to evaluate the particular situation. However, it is important that the qualified staff doing the assessment is familiar with the resident and the specific needs of the resident.

As a result of the assessment, the care plan is updated. It is imperative that appropriate communication of the changes and appropriate follow-through and follow-up of the care occur so that the intervention that has been chosen can be evaluated for effectiveness. Appropriate disciplines may need to participate at a later time.

42 **Is the same expected in respect to enablers?**

Yes, the same assessment and care planning is expected with enablers that meet the definition of a restraint.

43 **How do we establish that we have exhausted less restrictive measures? It is impossible without resulting in serious injury and expense.**

Determination of the type of restraint for a resident is a complex process. You need to assess what the resident's level of functioning is, what functioning is important to the resident to maintain, the resident's thoughts on use of a restraint for him/her, and what quality of life area will the use of the restraint improve, maintain or enhance. This is all contained in the restraint resident assessment protocol (RAP) included in the federal Resident Assessment Instrument (RAI) manual. Documentation of the results of this process will establish that you have tried less restrictive measures and they have failed. This would show the different methods that have been attempted and how monitoring for their effect was accomplished.

It is important to note that restraints do not ensure safety. Residents do die in restraints due to asphyxiation and other resultant trauma. The physical deterioration caused by continuous use of restraints can often be considered more detrimental to the resident than the alleged "safety" the restraint may or may not provide. To our knowledge there have been no legal decisions that have determined a restraint was appropriate and not used. There have been many successful legal actions because a restraint was used without proper assessment or need.

44 **When should a physician's order for a restraint be discontinued?**

A physician's order for a restraint should be discontinued when the comprehensive assessment conducted by the interdisciplinary team, including the physician, determines that the restraint is no longer a necessary and/or appropriate intervention for the individual resident.

45 **We have a resident in our facility with Parkinson's Disease whose tremors get worse at unscheduled times of the day**. **In order to adhere to the least restrictive restraint use, the comprehensive assessment deems the side/bed rail is necessary on a prn basis. How does one get an order to cover this need when "prn" orders for restraint use are no longer acceptable?**

The physician's order can address the when, why and the times the restraint is to be used or what conditions call for the restraint use. The interdisciplinary care plan can be more specific to when and for how long the restraint should be applied based on the resident's symptoms.

46 **Is there any time limit if a restraint is used (less than 2 hours on a less than daily basis)?**

No. The order can simply state "use daily up to 2 hours to control tremors."

47 **What happens when 7am-3pm staff feel a restraint is not needed, but the 3pm-11pm shift feels the resident needs a restraint?**

The interdisciplinary team, which should include staff representatives from both shifts, should be involved in the comprehensive assessment of the resident's needs on all shifts. The determination for restraint use should not be based on what the staff "feels" the resident needs but on the outcome of the assessment with and for the resident. If the 3pm-11pm staff, following an assessment outcome that restraints are not needed for this resident on their shift, still "feel" this resident needs restraints, a restraint reduction inservice program for the staff may be in order.

48 **What is the responsibility of Physical Therapy (PT) and Occupational Therapy (OT) regarding assessment for restraint use especially since so many therapy services are contracted and not available daily**. **Is there <u>mandated</u> participation for these disciplines for restraints or the Minimum Data Set (MDS)?**

The involvement of PT and OT in restraint assessment and care planning is not mandated by any regulation. However, it is good practice to involve an interdisciplinary team that may include a PT and/or an OT. These specialists can provide professional recommendations to the need, types, least restrictive, etc., restraints or enablers.

49 **What does a physician order need to say in a progression to lesser restrictive restraints?**

Based on the individual comprehensive assessment of the resident, the order should state: "May participate in restraint reduction in movement from current to a lesser or least restrictive use of restraints based on professional staff assessment." The care plan must indicate a progressive plan in moving to least restrictive restraint use over a period of time. It is not necessary to request a physician's order for every type of restraint while the interdisciplinary team is assessing and reducing restraints as appropriate.

50. **Do you need a written/verbal physician's order to take off a restraint during an assessment period?**

The federal regulations do not require a physician order. The regulations do expect that an interdisciplinary team, including the physician, will make this decision. This would include informing the physician, but not necessarily requiring an order. If there is informed consent for the restraint, this will need to be revoked or addressed in some manner.

The Wisconsin Administrative Code for Nursing Homes section HSS 132.60 (6)(b) does require a physician order that includes the reason for the restraint and the duration. In this instance the facility would need to contact the physician before removing the restraint.

PART 4. CHEMICAL RESTRAINTS

51. **What is a chemical restraint?**

In section HSS 132.60(6)(a)3, the state administrative code uses this language --**"**medication used primarily to modify behavior by interfering with the resident's freedom of movement or mental alertness.**"**

Federal language in 42 CFR 483.13(a), notes "medication that is used for discipline or convenience and not to treat medical symptoms."

52. **Are chemical restraints permitted for use in the nursing home?**

No.

53. **How can we determine if a drug is being used as a chemical restraint?**

BQC surveyors use 5 criteria to determine if a particular medication is being used as a chemical restraint:

1. Is the resident on a psychoactive medication?
2. Is there a medical diagnosis to support the use of the medication?
3. Has the Resident Assessment, including the behavior Resident Assessment Protocol (RAP), been done?
4. Does the plan of care have time-specific goals that are measurable and have behavioral interventions other than medication?
5. Was the resident or his/her representative involved in the process, with input into the decisions on the plan of care?

If the answer to all of these questions is yes, then our determination is that the medication use is reasonable medical practice and that the medication is not being used as a chemical restraint.

54. **Please provide current definitions and listings for "antipsychotic" and "psychotropic" medications.**

Antipsychotic medication is any medication used to treat a psychotic condition as described in 42 CFR 483.25(l)(2)(i) of the long term care regulations. This is on pages 124-128 of the State Operations Manual Transmittal 274 that contains all of the interpretive guidelines from HCFA under tags F329-31.

It is difficult to give an up-to-date list of these medications as the marketplace changes so frequently. A partial list is included on pages 120 of the same manual transmittal noted above and this list covers 95% of the medications used in the state.

Psychotropic medications are the same thing as psychoactive medications and these terms refer to any medication that is used to control behavior. It includes the above antipsychotics, antidepressants, antianxiety medications and sedatives, along with other medications that are used to control behavior such as lithium, Tegretol, valproic acid, Inderal, etc. Examples of these medications can also be found in the HCFA interpretive guidelines, on pages 114-124 and in the Resident Assessment Users Manual under the RAP for psychotropic drugs.

55. **How often must you try to reduce medications or medication doses?**

This depends on the medication and the reason for the treatment. There is no requirement to reduce the doses of antidepressants.

Antipsychotic medications should have a dose reduction considered every 6 months after the condition is initially controlled. If there is no clinical contraindication, an attempt to gradually reduce the medication would be expected.

Antianxiety medications should have a dose reduction attempt every 4 months, unless clinically contraindicated.

The sedative and hypnotic medications should not be used for more than 10 consecutive days without an attempt at dose reduction. These medications are intended to be used for temporary problems. Long term use indicates another medical problem that should be investigated.

The reason for these timing requirements for dose reductions is that the dose required to initially control a person is usually greater than the dose it takes to keep a person controlled, and the objective is to determine the minimum effective dose. Also, all other behavior interventions are effective in reducing the dose of medications after a long period of time for some medical symptoms.

The only exception to attempting a dose reduction is when there is a clinical contraindication. The definition of clinical contraindication is found in the federal regulations, 42 CFR 483.25(l)(2)(ii).

56. **What if you have tried unsuccessfully in the past?**

If you have two failed attempts about 4-6 months apart, and are also using other interventions for the behavior, then this would constitute a clinical contraindication to further dose reduction attempts. However, an individual's metabolism and excretion of the medication may have changed over time and a lower dose would be as effective. BQC surveyors look at the annual comprehensive assessment to see if the facility considered a dose reduction in relation to the specific case circumstances.

57. **Must you continue to try to reduce?**

Yes. You must continue to try to reduce unless clinically contraindicated as stated in question number 55 above.

58. **What documentation is required?**

Assessment: must have 7-14 day baseline of behaviors on all shifts (behavior RAP of MDS).

Plan of care: must list what specific behaviors are to be controlled, at what quantitative level, in what amount of time.

Behavior documentation for dementias are quantitative counts of specific behaviors.

Other documentation to show progress toward goal on plan of care.

59. **What if a physician refuses to reduce the medication dose? How can we be held responsible for reactions of a medical practitioner over whom we have no control?**

You must discuss this with the physician and, if not successful, we recommend that you enlist the help of your medical director. We would look for the physician's documentation in the resident's clinical record of why a dose reduction is not appropriate at this time. You can also suggest that the physician contact the Wisconsin Association of Medical Directors to get advice and direction and they can also be referred to BQC for clarification of the regulations, if that will help to resolve a situation. The physician may do a risk benefit analysis in the chart and the surveyors will accept this. If BQC has concerns about the physician services, a peer review physician will be consulted.

60. **Must there be a psychological evaluation for everyone on psychoactive medications? If so, who pays?**

No.

61. **The definition of chemical restraints is becoming so broad--is signed consent necessary, and for what drugs?**

At present, there is no requirement for signed consents for any medication. Many of the legal advisors for facilities recommend that in regard to high-risk drugs, i.e., vaccines or psychotropic medications, the facility obtain a signed informed consent to acknowledge that the risks of treatment have been explained. The federal government has proposed that any behavior control medication have informed consent, but this is not required at this time.

62. **Please develop a standard that nursing homes can use to obtain informed consent that will meet federal and state standards.**

Examples of the forms used by the state operated Intermediate Care Facilities for the Mentally Retarded for informed consent for medication are included as Attachments 1, 2, and 3 with this Q&A document. (The Intermediate Care Facility-Mentally Retarded regulations were the model in this area used for long term care). If a signed consent form is used, be sure to give the resident a copy for their reference.

There are several forms for antianxiety agents, antidepressants and antipsychotics. To use these forms, the facility circles the medication, indicates the dose range to be used, if the medication is different than stated, explains the expected results of using the medication, how long the treatment will be provided before a reassessment is done, and what side effects and/or risks are involved.

63. **Are there already existing or proposed standards for when psychotropic medication is appropriate and should be reduced?**

There are no standards that have been published as proposed or final regulations. However, the American Psychiatric Association has some guidelines that HCFA has incorporated into the regulations.

64. **What are the guidelines for assessment and follow-up documentation? What must be included? What medical assessment must be included? How often? By whom?**

The federal guidelines to follow are those found at 42 CFR 483.20 (b)(c) and (d).

The state regulations are located at HSS 132.52(5)(6) and HSS 132.60(1)(c).

65. **A resident is on a psychotropic medication and there are no negative side effects. The physician indicates in a progress note: "No dose reduction as resident is stable at this time." There have been no dose reductions in the past. Is the MD's note an acceptable contraindication? If the note was written by a psychiatrist would that make a difference?**

This would depend on the reason the medication was prescribed.

a. If the physician only writes "no dose reduction at this time," this would not be satisfactory. The physician must do a risk benefit analysis and describe why this is in favor of not doing a dose reduction. See clinical contraindication Note #3 in federal guidance to surveyors, F331, HCFA Transmittal 274.

b. If this were for an aggressive behavior or striking out at others and the resident had done this recently, then the statement may be acceptable.

c. If this is for a dementia or no behaviors have been noted in the last 6 months, then a dose reduction may be indicated.

The purpose is to see if the resident is at the minimal effective dose of the medication.

The federal definition of a clinical contraindication to a dose reduction is to have tried and failed twice in a 12-month period. These cases will, at BQC request, be reviewed by an independent physician, and there should be documentation as to the reason the attending physician does not feel this is indicated at this time.

The answer would not be different if the physician were a psychiatrist, but the reasons may be better explained by this person. We would also look to see what behavior interventions (other than medications) the facility has implemented, as medications alone are not the answer to behavior problems. Has a behavior specialist been consulted about methods to control the behaviors?

66. **For a resident, who is on a psychoactive medication that is considered reasonable medical practice and not a chemical restraint, is there a requirement for ongoing behavioral documentation/assessment in a quantitative manner? Is reduction necessary every 4 months for benzodiazepines and all others every 6 months, again if it is not a chemical restraint? We really need more education on chemical restraints especially if Wisconsin is seeing greater than 40% of their residents using psycho-active drugs.**

If the medication is used for dementias or organic mental syndromes, the answer is "yes." These medications are of limited value in dementias and the medical literature has not showed them to be effective in a number of cases, Because of this, the federal guidelines require that quantitative counts of specific behaviors be done in these circumstances.

If the medications are used for an approved use (i.e., Haldol for a psychosis, Xanax for panic attack, etc.), the medication literature shows these medications to be generally effective and quantitative counts of behaviors does not need to continue after the behavior has been controlled. The goals for therapy may now be measuring ADL or cognitive functioning, of which these medications may be an approach.

There are no indications for chemical restraints. Therefore, every medication used is not a chemical restraint, and is used to treat a medical condition. The following dose reduction guidelines still apply unless a clinical contraindication exists:

a. For antipsychotic: 6 months after the drug has been started.
b. For antianxiety: (Benzodiazepines) after 4 months of therapy because the manufacturers recommend a reassessment at this time and they have no data to show the medication is effective after 4 months.
c. Sedative/Hypnotic: after 10 days. This medication will loose its effect and can cause addiction, sleep reversal and rebound insomnia after this amount of time. An assessment for cause of the insomnia is critical to treat the symptom.

We agree that more education is needed for physicians, nurses, social services, nurse aides, family, etc. The BQC is working with the industry to develop and provide necessary training.

67. **Does the Power of Attorney for Health Care (POAHC) or guardian have the right to consent to psychoactive drug use? They cannot give permission for admission to a mental health facility or for psychiatric treatment. (This is, of course, assuming the POAHC has been activated by appropriate physician documentation).**

BQC currently has a request for a legal opinion on this topic.

As a general rule, use of psychoactive drugs should be specifically ordered by the court as part of the protective placement order, e.g., including the right to administer psychotropic medication, or the power to make such decision specified by the court in the guardianship decree.

The POAHC is less clear, as the surrogate was selected by the individual as his/her agent. You could go back to the court (probate) if doubt exists.

68. **Are there BQC regulations regarding Tardive Dyskinesia (TD) testing (how often, etc.) for psychotropic medications?**

The federal guidelines state that TD monitoring must be done. The standard of practice will dictate how, how often, by whom, etc. The facility should obtain a training manual for the test that they wish to use and follow the guidelines.

BQC surveyors look to see that the TD screen is done. Each individual assessment will determine how often the test is done. At the present time, the standard of practice is to do a baseline screen within the first 3 months of starting the therapy or upon admission to the facility, and every 6 months while on the medication.

PART 5. RESIDENT RIGHTS/FAMILY ISSUES

69. **When an assessment establishes that use of a physical restraint is not necessary, can the facility honor the resident's (family's) request that it be employed/utilized (e.g., does the resident's right to direct his care take precedent over the federal regulation directives to facilities on how care is to be provided?)**

Yes, the facility can honor the resident's choice. However, in this situation, the facility does need to continue ongoing assessment and evaluation of the care that is being provided, including physical restraint use. As the resident's situation changes, the type of restraint, alternatives, and the risk assessment need to be reevaluated on an ongoing basis to look at alternatives and to determine the least restrictive intervention that is acceptable to the resident.

It is important that these are informed decisions on the part of residents and their spokesperson and that they receive an explanation of potential negative outcomes of restraint use for the resident. The National Citizens Coalition for Nursing Home Reform (NCCNHR) has developed the booklet "Avoiding Physical Restraint Use: New Standards in Care" which is recommended for educating residents and their family and friends about risks and benefits of restraint use. Continuing education of the resident or of the spokesperson should be offered in relation to restraint usage and risks. We would look to see that this type of information has been provided to a competent resident or family. We would interview this resident or family person to determine that they were able to make an informed decision.

70. **Is there any difference between a resident's, a guardian's or a family member's right to insist on use of a restraint?**

In all situations, there must first be an assessment of a medical need for a restraint for the individual.

- A competent resident may give permission for the use of a restraint.
- A guardian of the person may give permission for the use of a physical restraint of an incompetent individual; there may be limits regarding the use of medications.
- An incapacitated person who has a power of attorney for health care (POAHC) who is authorized to address this issue can be represented by the power of attorney, assuming the POAHC has been activated.
- A family member of a competent resident has no legal right to "insist" on or give permission for a restraint.

A surrogate or legal representative cannot give the facility permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of the regulation solely because a surrogate or representative has approved or requested them.

The surrogate or representative, however, may exercise the right of informed consent based on the same information that would have been provided to the resident were he/she competent to make such an informed decision.

A physician may order a restraint but the resident, guardian or POAHC has the right to refuse the use of the restraint.

71. **Does informed consent actually have to be in writing?**

Yes, but there is no required form for informed consent. However, discussion with the resident detailing potential negative outcomes of restraint use and the resident's understanding, involvement in the care planning and consent to use the restraint must be documented in some manner in the resident's medical record. A signed consent form does not replace the assessment process that is required by federal regulations.

Examples of forms are included as attachments. These are samples only and not the only acceptable forms.

72. **We have a lot of problems with families who desire use of restraints and reject our policies and benefits of restraint reduction**. **What services can the Ombudsman provide to resolve these disputes over what is best for the resident?**

The Ombudsman can mediate conflicts between the family and the resident and with the facility, assess alternatives for each party's concerns and provide any necessary information. The Ombudsman can identify and encourage use of internal and external resources that can help solve problems. The Ombudsman represents the resident.

73. **If the Ombudsman sides with the family, and we honor their wishes, is the facility at risk with BQC?**

The Ombudsman's role is to seek voluntary resolutions to conflicts by negotiating solutions with the resident's wishes and interest at the center of the Ombudsman's efforts. When parties will not negotiate, voluntary resolution is not always possible.

Since the facility has ultimate risk and responsibility as primary caregiver to residents, recourse to court intervention is a way to protect themselves as well as the resident.

The Ombudsman's goal is to seek voluntary resolutions to conflicts. As part of that process, they can be called upon to help engage parties in negotiation, including BQC. If BQC disagrees with what the facility, resident and family find to be the best solution, the Ombudsman can support the facility in negotiations with BQC.

74. **<u>For the Incompetent Resident:</u> What if the facility interdisciplinary team decides pursuit of restraint reduction is appropriate and the physician and family disagree? What do we do?**

- Further discussion with physician and family, as both are part of the team.
- Intervention by facility medical director.
- Address concerns to facility's ethics committee.
- Provide physician and family with recommendations of the ethics committee.
- Discuss further with physician and family.
- If it is the facility's contention that the resident is in need of court intervention due to incompetence and inappropriate decisions are being made by surrogates, the facility should seek court intervention.

<u>For the Competent Resident:</u> What if the facility interdisciplinary team decides restraint reduction is appropriate and the physician and resident disagree?

It is the resident's right to refuse treatment under 42 CFR 483.10(b)(4). The facility is expected to assess the reasons for the resident's refusal, clarify and educate the resident as to the consequences of refusal, offer alternatives and continue to provide all other services.

75. **What of a situation where the interdisciplinary team recommends restraints and the family/resident elect to go without and injury subsequently occurs? What do we do next?**

Prior to the resident/family decision, the facility needs to educate the individual of the risks, benefits, consequences of use of restraints or refusal to use restraints. This is informing and obtaining consent from the individual prior to the use or refusal to use restraints. Assuming this has been done, then the resident and family will be aware that there are risks and are aware of the pros and cons of taking such risk. If the injury occurs because there has been a change of condition, then the care planning needs to respond to this change.

76. **Suppose, at time of admission, the resident's family threatens a law suit "if my mother falls." The family insists on restraints even prior to an assessment being completed. If a new resident comes from another facility (e.g., hospital, mental health unit) and a restraint is already in use, do we leave it in place or take it off until all assessments are complete?**

There have been searches of the legal literature that have not produced any case in which a facility had a successful legal action because of not using a restraint. The legal literature is full of successful legal action relating to inappropriate use of restraint.

For a newly admitted resident who enters your facility with a physician's order for a restraint, and it is properly handled as a restraint, you may leave the restraint in place until the comprehensive assessment is completed.

Physician orders for immediate care are those written orders facility staff need to provide essential care to the resident, consistent with the resident's mental and physical status upon admission. These orders should, at minimum include dietary, drugs (if necessary), and routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan.

Nursing care initiated in the hospital shall be continued immediately upon admission to the nursing home unless ordered otherwise by the admitting physician. *(s. HSS 132.60(1)(c), Wis. Adm. Code).*

77. **What approaches are recommended for changing staff attitudes that resident safety is jeopardized by restraint reduction?**

The following suggestions have proven to be successful in many facilities:

1. Stress that times have changed and we now know that restraints should no longer be used routinely because their risks outweigh their benefits.

2. Stress the residents' quality of life: removing restraints can make them happier and restore their dignity.

3. Role play with your staff: restrain staff members in a wheel chair, have them sit in a geri-chair with a tray, use mitten restraints on staff's hands or have them try on a physical restraint of some type for 10 or 15 minutes.

4. Involve all staff disciplines in the nursing home because each has a role to play in restraint reduction.

5. Use resident restraint reduction "success stories" in staff meetings as reinforcement and morale boosters for the staff, giving specific staff members credit when appropriate.

From "The Joyful Road to Restraint-Free Care" Joanne Rader R.N., M.N., Benedictine Institute for Long Term Care writes:

> "For a restraint reduction program to be effective, it is essential to orient staff to its importance. It is equally important to continue educating and supporting them throughout the implementation process and on an ongoing basis. Many facilities use the care planning conference as a way to educate staff and families about the restraint reduction process.
>
> Consider including in training:
>
> 1. A review of negative effects and burdens of restraints;
> 2. The resident assessment process and tools;
> 3. Alternative interventions;
> 4. Fall prevention and assessment;
> 5. Ways to stimulate creative problem solving;
> 6. Importance of residents' rights."